| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335827 | A. Building<br>B. Wing | 10/03/2023 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Grand Rehabilitation and Nrsg at River Valley | 140 Main Street<br>Poughkeepsie, NY 12601 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>45478<br><br>Based on observation, interview, and record review during a recertification survey the facility did not ensure that comprehensive care plans were reviewed and revised by the interdisciplinary team. This was identified for 1 of 6 residents (Resident # 59) reviewed for accidents. Specifically, Resident # 59 had a fall on 2/4/23 and a fall with injury on 2/28/23 and the Fall Care Plan was not revised.<br><br>Findings include:<br><br>Resident # 59 had diagnoses including arthritis, lymphedema, and peripheral neuropathy.<br><br>The Annual Minimum Data Set (MDS-an assessment tool) dated 8/26/23, documented the resident's cognition was intact. Resident #59 needed limited assistance of one person for bed mobility, transfer, and toileting.<br><br>The Accident/Incident (A/I) reports dated 2/4/23 and 2/28/23, documented Resident #59 falls when getting up to ambulate with their walker.<br><br>The fall care plan created 10/7/19, documented the resident had an actual fall related to decreased mobility, depression, psychoactive drug use, and use of psychoactive drug use. It further documented the resident had an actual fall while out on pass on 11/10/19 and on 9/24/21 an actual fall with no injury.<br><br>There was no documented evidence the fall care plan was reviewed and revised for the falls Resident #59 had on 2/4/23 and 2/28/23.<br><br>During an interview on 10/03/23 at 3:18 PM, the Director of Nursing (DON) stated the Assisted Director of Nursing (ADON) and DON were responsible for updating care plans. The DON stated when they reviewed the electronic medical record there were no updates made to the fall care plan. The DON stated the registered nurse (RN) that completed the A/I reports should have updated the care plans but did not.<br><br>415.11 (c)(2)(i-iii) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
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